		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Hwy - Box C (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** ( )

IDPA ID Number: 37-0841562008

Date of Initial License for Current Owners: 1969

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark Havrilka

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William O. Buskirk, CPA

(Firm Name & Address) Eck, Schafer & Punke, LLP
600 East Adams Springfield, IL 62701-1624

(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,738	1
2	0	Skilled Pediatric (SNF/PED)	0		2
3	0	Intermediate (ICF)	0		3
4	0	Intermediate/DD	0		4
5	32	Sheltered Care (SC)	32	11,712	5
6	0	ICF/DD 16 or Less	0		6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,403	7,796	102	14,301	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,846	5,380		7,226	12
13	DD 16 OR LESS					13
14	TOTALS	8,249	13,176	102	21,527	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.42%

D. How many bed-hold days during this year were paid by Public Aid?
213 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: June 30, 2000 Fiscal Year: June 30, 2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	136,187	13,075	8,744	158,006		158,006		158,006			1
2	Food Purchase		107,529		107,529		107,529	(133)	107,396			2
3	Housekeeping	57,706	8,691		66,397		66,397		66,397			3
4	Laundry	28,534	12,550		41,084		41,084		41,084			4
5	Heat and Other Utilities			57,726	57,726		57,726	(4,043)	53,683			5
6	Maintenance	25,785	7,215	34,010	67,010		67,010	3,442	70,452			6
7	Other (specify):*											7
8	**TOTAL General Services**	248,212	149,060	100,480	497,752		497,752	(734)	497,018			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	660,291	43,021	2,115	705,427		705,427		705,427			10
10a	Therapy			4,811	4,811		4,811		4,811			10a
11	Activities											11
12	Social Services	65,764	984	4,654	71,402		71,402	(511)	70,891			12
13	Nurse Aide Training											13
14	Program Transportation		348		348		348		348			14
15	Other (specify):* Contractual Services			112,709	112,709		112,709		112,709			15
16	**TOTAL Health Care and Programs**	726,055	44,353	124,289	894,697		894,697	(511)	894,186			16
	C. General Administration											
17	Administrative	54,237	2,417	84,266	140,920		140,920	(61,401)	79,519			17
18	Directors Fees											18
19	Professional Services			256	256		256	9,781	10,037			19
20	Dues, Fees, Subscriptions & Promotions			15,079	15,079		15,079	(8,565)	6,514			20
21	Clerical & General Office Expenses	33,006	2,381	23,357	58,744		58,744	12,942	71,686			21
22	Employee Benefits & Payroll Taxes			151,410	151,410		151,410	116	151,526			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,886	4,886		4,886	1,316	6,202			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			8,320	8,320		8,320	723	9,043			26
27	Other (specify):*											27
28	**TOTAL General Administration**	87,243	4,798	287,574	379,615		379,615	(45,088)	334,527			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,061,510	198,211	512,343	1,772,064		1,772,064	(46,333)	1,725,731			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beulah Land Christian Home #0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			106,264	106,264		106,264	3,988	110,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,773	47,773		47,773	(1,773)	46,000			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			154,037	154,037		154,037	2,215	156,252			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			341	341		341		341			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,608	23,608		23,608		23,608			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			23,949	23,949		23,949		23,949			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,061,510	198,211	690,329	1,950,050		1,950,050	(44,118)	1,905,932			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(133)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,399)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	36	30		9
10	Interest and Other Investment Income	(1,773)	32		10
11	Discounts, Allowances, Rebates & Refunds	216	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(511)	12		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,081)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Mach, Act. Rev.	(250)	17		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,895)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(28,223)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,223)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,118)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Beulah Land Christian Home

ID# 0006767

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine	$ 750	17	1
2	Unrealized Loss on Market	(3,701)	17	2
3	Gain on Sale of Investment	2,701	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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65				65
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69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(250)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(133)	0	0	0	0	0	0	0	0	0	0	(133)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,399)	356	0	0	0	0	0	0	0	0	0	(4,043)	5
6	Maintenance	0	3,442	0	0	0	0	0	0	0	0	0	3,442	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,532)	3,798	0	0	0	0	0	0	0	0	0	(734)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(511)	0	0	0	0	0	0	0	0	0	0	(511)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(511)	0	0	0	0	0	0	0	0	0	0	(511)	16
	C. General Administration													
17	Administrative	(250)	(61,151)	0	0	0	0	0	0	0	0	0	(61,401)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,781	0	0	0	0	0	0	0	0	0	9,781	19
20	Fees, Subscriptions & Promotions	(9,081)	516	0	0	0	0	0	0	0	0	0	(8,565)	20
21	Clerical & General Office Expenses	216	12,726	0	0	0	0	0	0	0	0	0	12,942	21
22	Employee Benefits & Payroll Taxes	0	116	0	0	0	0	0	0	0	0	0	116	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,316	0	0	0	0	0	0	0	0	0	1,316	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	723	0	0	0	0	0	0	0	0	0	723	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,115)	(35,973)	0	0	0	0	0	0	0	0	0	(45,088)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,158)	(32,175)	0	0	0	0	0	0	0	0	0	(46,333)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	36	3,952	0	0	0	0	0	0	0	0	0	3,988	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,773)	0	0	0	0	0	0	0	0	0	0	(1,773)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,737)	3,952	0	0	0	0	0	0	0	0	0	2,215	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,895)	(28,223)	0	0	0	0	0	0	0	0	0	(44,118)	45

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc.	100.00%	$ 356	$ 356	1
2	V	6	Maintenance				3,442	3,442	2
3	V	17	Administration	79,152			18,001	(61,151)	3
4	V	18	Directors						4
5	V	19	Professional Services				9,781	9,781	5
6	V	20	Fees/Subscriptions/Promotions				516	516	6
7	V	21	Clerical				12,726	12,726	7
8	V	22	Employee Benefits	5,700			5,816	116	8
9	V	23	In-Service						9
10	V	24	Travel and Seminar				1,316	1,316	10
11	V	26	Insurance				723	723	11
12	V	30	Depreciation				3,952	3,952	12
13	V								13
14	Total			$ 84,852			$ 56,629	$ * (28,223)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996-A GR Bonds	x		1996-A		07/01/96	$ 225,000	$ 212,550	07/01/21	0.0800	$ 17,121	1
2	Due to CHI Bond Fund	x		Operations	$3,000.00	N/A	66,545	64,017	N/A	0.0850	4,017	2
3	1998-C GR Bonds	x		1998-C	$8,090.61	11/01/98	480,060	383,591	01/05/05	0.0650	26,635	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$11,090.61		$ 771,605	$ 660,158			$ 47,773	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 771,605	$ 660,158			$ 47,773	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	This w/p n/a.	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,000	Various	$ 19,470	1
2	Home Office			3,390	2
3	TOTALS	16,000		$ 22,860	3

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1982	1982	$ 1,279,926	$ 31,998	40	$ 31,998	$	$ 577,297	4
5	32		1974	1974	417,998	8,360	50	8,396	36	247,897	5
6											6
7	Home Office				24,188	790		790		10,502	7
8											8
	Improvement Type**										
9	Land Improvement			1974	10,762		20			10,762	9
10	Land Improvement			1977	7,756	155	50	155		3,644	10
11	Roof Repairs			1978	5,600		3			5,600	11
12	Insulated Windows			1979	16,273	370	44	370		7,647	12
13	Smoke Detectors			1979	1,797		15			1,797	13
14	Sewer Line			1980	5,740	191	30	191		3,757	14
15	Ceiling Replaced			1981	1,118	26	43	26		520	15
16	Water Line			1981	6,585	220	30	220		4,067	16
17	Heating & A/C			1982	25,614	1,281	20	1,281		23,111	17
18	Bldg Improvement			1982	28,428	711	40	711		12,828	18
19	Parking Lot			1982	1,550	10	15	10		1,550	19
20											20
21	Bldg Improvement			1982	7,375	184	40	184		3,282	21
22	Landscaping			1982	6,984	1	10	1		6,984	22
23	Bldg Improvement			1982	36,352	909	40	909		15,980	23
24	Insulation			1983	4,400	147	30	147		2,572	24
25	Parking Lot			1983	28,308	2	15	2		28,308	25
26	Improvements			1983	2,925	98	30	98		1,683	26
27											27
28	Parking Lot			1983	23,657		15			23,657	28
29	Landscaping			1983	3,911	1	10	1		3,911	29
30	Parking Lot Lighting			1983	3,642	182	20	182		3,049	30
31	Tiling under Parking Lot			1984	1,755		10			1,755	31
32	Land Improvement - 1/2			1985	295		10			295	32
33	Hot Water System			1985	1,577	79	20	79		1,218	33
34	Edge Protectors, Etc			1985	507	25	15	25		507	34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,955,023	$ 45,740		$ 45,776	$ 36	$ 1,004,180	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Light Fixtures			1985	406	14	15	14		406	9
10	Garage Work			1985	23,170	768	15	768		23,170	10
11	Ceiling Tiles			1985	225	15	15	15		225	11
12	Bldg Improvement			1986	36,762	919	40	919		13,326	12
13	Landscape Planter 1/2			1986	923	3	10	3		923	13
14	Sidewalks			1987	680		10			680	14
15	Light Fixtures - 1/2			1987	610		10			610	15
16	Window 1/2			1987	840	42	20	42		553	16
17	Sidewalks 1/2			1987	10,600	424	25	424		5,371	17
18	Remodeling 1/2			1987	634	42	15	42		528	18
19	Hot Water System 1/2			1988	979	49	20	49		604	19
20	Chg Water Piping 1/2			1988	390	20	20	20		247	20
21	Water Heater Consult			1988	961	64	15	64		784	21
22	Appraisal Fee			1988	3,500	233	15	233		2,796	22
23	Fire Alarm Dialer			1988	550	28	20	28		334	23
24	Door Alarm System			1988	1,900	95	20	95		1,124	24
25	Vinyl Siding			1988	3,410	171	20	171		2,009	25
26	Moving Fire Hydrant			1989	510	34	15	34		391	26
27	Carpeting			1989	860		5			860	27
28	Door Monitor Panel			1989	1,980	33	10	33		1,980	28
29	Compressors (2)			1989	924	19	10	19		924	29
30	Compressors			1989	2,306	35	10	35		2,306	30
31	Concrete Walk			1989	1,215	61	20	61		656	31
32	Painting Sheltercare			1989	1,594		5			1,594	32
33	Compressor (1)			1989	693	20	10	20		693	33
34	Outdoor Lighting			1989	434	15	10	15		434	34
35	Outdoor Lighting			1990	1,786	115	10	115		1,786	35
36	TOTAL (lines 4 thru 35)				$ 98,842	$ 3,219		$ 3,219	$	$ 65,314	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Emerg Power Kitchen Light			1990	329		5			329	9
10	Lavatories/Faucets			1990	1,679		5			1,679	10
11	Carpeting			1990	300		5			300	11
12	Rock			1990	302	30	10	30		293	12
13	Compressor			1991	1,828	183	10	183		1,693	13
14	Roof Repair			1991	2,340	1	6	1		2,340	14
15	Insulating Glass			1991	2,256	68	33	68		589	15
16	Smoke/Heat Detectors			1991	885	89	10	89		764	16
17	Door Monitor			1992	1,440	144	10	144		1,116	17
18	Room Windows (3)			1992	2,696	135	20	135		1,046	18
19	A/C Units (5)			1992	5,859	732	8	732		5,673	19
20	Energy Management			1992	658	66	10	66		506	20
21	Repair and Seal Parking Lot			1993	3,209		6			3,209	21
22	Sinks/Faucets			1993	537	1	5	1		537	22
23	Door Monitor			1993	1,700	170	10	170		1,204	23
24	Mix Valve/Faucet			1993	2,953	295	10	295		2,090	24
25	Auto Sprinkler			1993	580	58	10	58		396	25
26	Door Access System			1993	602	60	10	60		400	26
27	Wallcoverings			1993	5,315		5			5,315	27
28	Carpet/Wallpaper			1993	14,418		5			14,418	28
29	Outside LTS			1994	2,099	210	10	210		1,365	29
30	Roofing Project Shelter			1994	62,189	4,146	15	4,146		24,876	30
31	Seal Parking Lot			1994	14,237		3			14,237	31
32	Install Carrier Furnace			1994	1,877	188	10	188		1,112	32
33	Disposer			1994	1,475	148	10	148		839	33
34	Landscaping			1995	1,839	184	10	184		1,012	34
35	Nurse Call System			1995	1,040	69	15	69		368	35
36	TOTAL (lines 4 thru 35)				$ 134,642	$ 6,977		$ 6,977	$	$ 87,706	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Upstairs Lib/Comp Room			1995	1,801	180	10	180		930	9
10	Garage Doors			1995	676	114	5	114		676	10
11	Wanderguard			1995	4,094	409	10	409		2,079	11
12	Smoke/Fire Alarms			1995	957	96	10	96		488	12
13	A/C Heating Units			1995	2,326	291	8	291		1,479	13
14	Landscaping			1995	6,676	668	10	668		3,396	14
15	Smoke Detectors			1995	766	77	10	77		379	15
16	Heating/AC Units			1995	4,652	582	8	582		2,813	16
17	Carrier Central A/C			1995	2,748	275	10	275		1,306	17
18	Heating/AC Units			1995	2,326	291	8	291		1,358	18
19	Water Heater			1996	6,263	626	10	626		2,765	19
20	200 Gallon Storage Tank			1996	4,115	412	10	412		1,785	20
21	Remodel Nursing Wing			1996	3,249	650	5	650		2,708	21
22	Heating/AC Units			1996	5,235	654	8	654		2,398	22
23	Parking Lot Lights			1997	1,864	373	5	373		1,306	23
24	Mixer/Amp			1997	975	98	10	98		310	24
25	Water Heater			1997	13,453	1,345	10	1,345		4,147	25
26	Eyewash Station			1997	555	111	5	111		324	26
27	Exit Lights			1997	1,102	110	10	110		312	27
28	Energy Management System			1997	14,670	734	20	734		2,019	28
29	York C/A Unit			1997	7,839	784	10	784		2,156	29
30	Floor Covering			1997	1,856	371	5	371		1,020	30
31	Wall Covering Sit & Bath			1998	2,574	515	5	515		1,288	31
32	Floor Covering - Sit & Bath			1998	1,145	229	5	229		553	32
33	Concrt FNC/Dumpster			1998	3,571	357	10	357		744	33
34	Carpeting			1998	8,739	1,748	5	1,748		3,496	34
35	Wallpaper			1998	7,497	1,499	5	1,499		2,998	35
36	TOTAL (lines 4 thru 35)				$ 111,724	$ 13,599		$ 13,599	$	$ 45,233	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1998	578	116	5	116		222	9
10	Room Signs			1998	2,270	454	5	454		719	10
11	Paint/Wallpaper/Carpet			1999	17,404	1,740	10	1,740		2,610	11
12	Remodel Nurses Station			1999	2,700	180	15	180		210	12
13	Floor Tile/Cove Base			2000	1,144	191	5	191		191	13
14	Carpet/Cove Base 2 Rooms			2000	576	86	5	86		86	14
15	A/C Grill Covers (13)			2000	546	73	5	73		73	15
16	Shelter Care Hallway CA			2000	3,686	491	5	491		491	16
17	Floor Covering			2000	1,040	121	5	121		121	17
18	Fire Alarm System			2000	32,965	1,374	10	1,374		1,374	18
19	Floor Tile/Cove Base			2000	1,755	146	5	146		146	19
20	Remodel - Chapel/Act/Bs/Dr			2000	10,705	179	10	179		179	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 75,369	$ 5,151		$ 5,151	$	$ 6,422	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 245,554	$ 28,627	$ 28,627	$	Various	$ 127,615	37
38	Current Year Purchases	38,466	1,762	1,762		Various	1,762	38
39	Fully Depreciated Assets	248,029				Various	247,929	39
40	Home Office	21,113	2,179	2,179		Various	17,167	40
41	TOTALS	$ 553,162	$ 32,568	$ 32,568	$		$ 394,473	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	2000 Ford Van	2000	$ 47,500	$ 1,979	$ 1,979	$	4	$ 1,979	42
43										43
44	Home Office			4,598	983	983			1,417	44
45										45
46	TOTALS			$ 52,098	$ 2,962	$ 2,962	$		$ 3,396	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,003,720	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 110,216	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 110,252	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 36	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,606,724	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Land	$ 202,868	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 202,868	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 92

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,475	$	$ 1,475
2	Books and Supplies					
3	Classroom Wages	(a)		2,760		2,760
4	Clinical Wages	(b)		1,202		1,202
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			250		250
9	TOTALS		$	$ 5,687	$	$ 5,687
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,687			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	6
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ This w/p is n/a.		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,786	$	1
2	Cash-Patient Deposits	4,347		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,416)	83,622		3
4	Supply Inventory (priced at FIFO)	14,735		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	1,182		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 108,671	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	222,337		13
14	Buildings, at Historical Cost	2,207,703		14
15	Leasehold Improvements, at Historical Cost	143,711		15
16	Equipment, at Historical Cost	579,552		16
17	Accumulated Depreciation (book methods)	(1,577,638)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	396,847		21
22	Other Long-Term Assets (spe Bequests	142,500		22
23	Other(specify): Deferred Bond cost	12,104		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,127,116	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,235,786	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,080	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,113		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,290		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Reserve for InvestmentAllowance	2,839		36
37	Funds in Trust	4,347		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 112,668	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	687,158		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 687,158	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 799,826	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,435,960	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,235,786	$	48

***(See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,475,891	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,475,891	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(39,931)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (39,931)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,435,960	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,073,412	1
2	Discounts and Allowances for all Levels	(265,706)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,807,706	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,260	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,335	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,595	23
	D. Non-Operating Revenue		
24	Contributions	73,234	24
25	Interest and Other Investment Income***	26,584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 99,818	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain/Loss Sale of Equip/Investment	2,701	28
28a	Unrealized Holding Gains on Investment	(3,701)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,000)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,910,119	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	497,752	31
32	Health Care	894,697	32
33	General Administration	379,615	33
	B. Capital Expense		
34	Ownership	154,037	34
	C. Ancillary Expense		
35	Special Cost Centers	341	35
36	Provider Participation Fee	23,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,950,050	40
41	**Income before Income Taxes (line 30 minus line 40)****	(39,931)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (39,931)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,830	2,022	$ 40,756	$ 20.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,472	6,046	127,007	21.01	3
4	Licensed Practical Nurses	9,694	10,712	159,725	14.91	4
5	Nurse Aides & Orderlies	28,833	31,860	310,824	9.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	5,508	6,086	65,764	10.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,122	15,604	136,187	8.73	15
16	Dishwashers					16
17	Maintenance Workers	1,721	1,902	25,785	13.56	17
18	Housekeepers	7,657	8,461	57,706	6.82	18
19	Laundry	2,592	2,864	28,534	9.96	19
20	Administrator	1,695	1,873	54,237	28.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,860	2,055	22,278	10.84	23
24	Clerical	990	1,094	10,728	9.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	1,742	1,925	21,979	11.42	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,716	92,504	$ 1,061,510 *	$ 11.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	201	$ 8,744	1.3	35
36	Medical Director				36
37	Medical Records Consultant	22	1,241	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	600	10a.3	39
40	Physical Therapy Consultant	21	1,521	10a.3	40
41	Occupational Therapy Consultant	5	334	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	17	1,034	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	54	4,535	12.3	45
46	Other(specify) P.T Asst.	23	1,523	10a.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	427	$ 19,532		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas A. Novy	Administrator		$ 54,237
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,237

B. Administrative - Other

Description	Amount
Marketing	$ 5,114
Management Fee	79,152
TOTAL (agree to Schedule V, line 17, col. 3)	$ 84,266
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Booth & Little	Legal	$ 34
Systematic Management		69
Booth & Antoline	Legal	153
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 256

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,268
Unemployment Compensation Insurance	5,700
FICA Taxes	76,761
Employee Health Insurance	43,066
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	4,798
Employee Physicals	360
Worker's Comp. Medical Expense	458
Related Party Adjustment	(5,700)
Home Office Allocation	5,816
TOTAL (agree to Schedule V, line 22, col.8)	$ 151,526

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotion	10
Subscriptions	1,094
Membership Dues	3,784
Software License Fees	857
Fees	253
Home Office Allocation	516
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,514

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,950
Seminar Expense	2,837
Training Materials & Books	100
Home Office Allocation	1,316
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,202

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **INCA--$3232.50**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,863** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,608**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **133**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.